

## **1.0 Description of the Procedure**

Ocular photodynamic therapy (OPT) is a treatment approved by the Food and Drug Administration for age-related macular degeneration (AMD), the most common cause of blindness in the elderly. OPT includes the infusion of a photosensitive drug with a very specific absorption peak. The drug identifies and adheres to diseased tissue. Infusion is followed by targeted irradiation of the diseased tissue. OPT is only covered in conjunction with the drug Verteporfin.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 Special Provisions**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at <http://www.dhhs.state.nc.us/dma/prov.htm>.

## **3.0 When the Procedure is Covered**

OPT is covered for AMD with predominately classic subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies greater than 50 percent of the area of the entire lesion) as determined by a fluorescein angiogram at the most recent visit.

## **4.0 When the Procedure is Not Covered**

OPT is not covered when the criteria in **Section 3.0** are not met. Other uses of OPT are not covered.

## **5.0 Restrictions for and Limitations on Coverage**

1. The recipient must have a diagnosis of choroidal neovascularization, exudative or senile macular degeneration.
2. Recipients may receive up to five treatments per eye per year with a maximum of ten treatments per eye during a 2-year-period.
3. Separate reimbursement is not allowed for intravenous infusion services. It is included in payment for 67221.
4. Providers must maintain documentation including fluorescein angiogram and submit to DMA or its fiscal agent upon request.

## **6.0 Providers Eligible to Bill for the Procedure**

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this service.

## **7.0 Additional Requirements**

There are no additional requirements.

## **8.0 Billing Guidelines**

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

### **8.1 Claim Type**

Providers bill professional services on the CMS-1500 claim form.

### **8.2 Diagnosis Codes that Support Medical Necessity**

The only ICD-9-CM diagnosis that supports medical necessity is 362.52.

### **8.3 Procedure Codes**

The CPT and HCPCS codes that are covered under this policy include:

#### **For the procedure:**

Dates of service January 1, 2001 through December 31, 2001:

- 67221 – photodynamic therapy (includes intravenous infusion for destruction of localized lesion of choroid)
- G0184 – for the second eye at a concurrent session

Dates of service January 1, 2002 and after:

- 67221 – photodynamic therapy (includes intravenous infusion for destruction of localized lesion of choroid)
- 67225 – photodynamic therapy, second eye, at single session

**For verteporfin (Visudyne):**

Dates of service January 1, 2001 through December 31, 2001:

- J3490 – Requires invoice indicating the recipient's name and Medicaid identification number (MID), the name of the medication, the dosage given, the National Drug Code (NDC) number(s) from the vial(s) used, the number of vials used, and the cost per dose.

Dates of service January 1, 2002 and after:

- J3395 – No invoice is required.

**8.4 Reimbursement Rate**

Providers must bill their usual and customary charges.

**9.0 Policy Implementation/Revision Information**

**Effective Date:** January 1, 2001

**Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
7/01/04	Section 8.3	The CPT and HCPCS codes covered under the policy were revised.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.